IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

JAMES J. MULHOLLAND and ANNA MULHOLLAND, Plaintiffs, v. UFCW LOCAL 1776 PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND, Defendant.	CIVIL NO. 06-304(NLH) **OPINION**

APPEARANCES:

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HILLMAN, District Judge

This matter comes before the Court on the motion of Plaintiffs James J. Mulholland and Anna Mulholland for summary judgment, and on the cross-motion for summary judgment of Defendant UFCW Local 1776 Participating Employers Health and Welfare Fund. For the reasons expressed below, Plaintiffs' motion will be denied, and Defendant's motion will granted in part and denied in part.

I. BACKGROUND

Defendant is an employee health and welfare plan (the "Fund") established under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001. Plaintiff James Mulholland is a participant of the Fund and Plaintiff Anna Mulholland is a covered dependant. On February 19, 2001, Mrs. Mulholland suffered personal injuries as a result of a slip-and-fall accident. Mrs. Mulholland received a total of $27,736.52 in medical and prescription benefits as a dependent covered by the Fund.

On February 4, 2003, the Mulhollands filed a personal injury suit in state court to recover damages for the injuries caused by the accident. Subsequently, the Fund notified the Mulhollands that it was asserting a subrogation lien against any recovery obtained by them. On April 11, 2005, the Mulhollands' attorney notified the Fund that the personal injury suit had been settled for $147,500.00. The letter also indicated that the Mulhollands disputed the validity of the Fund's subrogation lien and, accordingly, would place the full settlement amount in escrow pending resolution of the matter.

The Mulhollands have moved for summary judgment, arguing that the Fund is not entitled to a suborgation lien against their personal injury settlement recovery. The Fund has also moved for summary judgment, arguing that because the Mulhollands' medical

and prescription expenses related to the slip-and-fall accident were paid by the Fund, those expenses may be recouped from the Mulhollands' settlement recovery.

II. DISCUSSION

A. Summary Judgment Standard

Summary judgment is appropriate where the Court is satisfied that "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Celotex Corp. v. Catrett, 477 U.S. 317, 330 (1986); Fed. R. Civ. P. 56(c). If review of cross-motions for summary judgment reveals no genuine issue of material fact, then judgment may be entered in favor of the party deserving of judgment in light of the law and undisputed facts. See Iberia Foods Corp. v. Romeo Jr., 150 F.3d 298, 302 (3d Cir. 1998) (citation omitted).

B. The Parties' Arguments

The Mulhollands contend that the Fund did not have the right to assert a subrogation lien on their recovery from a third party. The Mulhollands first argue that nothing in the Trust Agreement, one of the Fund's primary plan documents, authorizes the Fund to assert a right of subrogation. Second, even if there were such a right, the Mulhollands argue that the Fund could only recover benefits paid by the Fund--i.e., self-insured benefits--

and not benefits paid by another insurer. The Mulhollands contend that their benefits were paid by another insurer, Independence Blue Cross/Pennsylvania Blue Shield ("IBC"), and are, thus, unrecoverable. Finally, the Mulhollands argue that because the lien was asserted in bad faith, they are entitled to reimbursement of counsel fees and costs.

The Fund contests the Mulhollands' arguments, and argues that the Fund is entitled to, and permitted to, be reimbursed for the benefits it paid to them because the Fund paid those benefits directly out of the Fund. Even though IBC acts as an administrator for the Fund and "pays" participants' claims, and even though the Fund carries "stop-loss" insurance,[1] those benefits paid to the Mulhollands were self-insured benefits, recoverable under the terms of the plan. The Fund is also seeking attorneys' fees and costs.

C. Analysis

The primary issue that must be decided is whether the benefits paid to the Mulhollands were paid out of the Fund--if they were not, then there is no need to address whether the Fund

[1] "Stop loss" insurance policies insure employee benefits plans, not plan participants, against catastrophic loss to the plans where their payout for medical benefits exceed a certain specific loss (for individual participants) or aggregate loss (for all participants) in a given period. See Bill Gray Enterprises, Inc. Employee Health and Welfare Plan v. Gourley, 248 F.3d 206 (3d Cir. 2001).

may assert a subrogation lien to recover them.

1. Whether the benefits were paid out of the Fund

The policies and procedures of the Fund are set forth in (1) the Agreement and Declaration of Trust ("Trust") and (2) the Summary Plan Description ("SPD"). The Trust authorizes a Board of Trustees to administer the Fund, and the SPD outlines the benefits to be provided, the rights and obligations of participants as to any benefits that are received, and the Funds' right to subrogation.

With respect to subrogation or reimbursement of costs and benefits, the SPD[2] states that a participant must notify the Fund whenever settlement payments related to a claim for benefits are received from a third party. It provides:

> The Fund is entitled to 100% reimbursement of all costs and benefits, except as may be specifically agreed to by the Fund in writing, when you receive any payment from another party, if the Fund has paid or incurred, or will incur in the future, any such costs and/or benefits, . . . if the Fund has paid or incurred or will incur in the future, any such costs and/or benefits.

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[2]Two different versions of the SPD have been attached to the parties' motions and related briefs. The Mulhollands' brief in support of their motion for summary judgment (at Exhibit B) and the Fund's opposition to the Mulhollands' motion for summary judgment (at Exhibit 3) each include a 97-page version of the "Plan IV Summary Plan Description," which is dated "9/01." The Fund's cross-motion for summary judgment includes (at Exhibit 1) a 58-page version of the "Plan IV Summary Plan Description," which is undated. It is unclear why the Fund relies on two different versions of the SPD. However, since both parties rely on it, the 97-page SPD dated "9/01" is the relevant SPD. In any event, the discrepancies between the two SPDs are immaterial.

(Pl.'s Summ. J. Mot. Ex. B at 93.)[3]

With regard to the Fund's relationship with IBC, during the relevant period, the Fund was engaged in a National Account Administrative Services Agreement ("Services Agreement") with IBC. The Services Agreement set forth the terms of the agreement under which IBC provided "cost-plus stop-loss administrative services" for the Fund, "which offers health care benefits to eligible individuals associated" with the Fund. (Def.'s Mot. Summ. J. Ex. 4, at 1.) Under this agreement, the Fund was liable to IBC for both claims expenses and retention charges.[4] The agreement also provides, "In all events, the Sponsor [i.e., the Fund] shall be liable for the full amount of any benefits covered under the Benefit Program for the health claim that is the subject of the claim." (Id. at 18.) The agreement, however,

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[3]The 58-page SPD provides,

> The Fund has the right of reimbursement when you file any claim for benefits where the events that caused the claim are or may be the fault of, or may be payable by, any other party. In these cases, you must sign an agreement to reimburse the Plan before it will pay any claims.
>
> The agreement states that you are legally obligated to notify the Fund if you receive payment from a third party, such as . . . a result of a lawsuit. . . . The Plan is entitled to reimbursement from any party if the Plan has paid benefits.

(Def.'s Summ. J. Mot. Ex. 1.)

[4]Claims expenses generally include hospital and professional services. The retention charge is a fee paid to IBC, based on the number of plan participants, for administering the benefits plan. (Def.'s Summ. J. Mot. at Ex. 3.)

does not delineate what types of claims it applies to--e.g., medical treatment, prescription drugs, vision, etc.--but rather generally states that it relates to the Fund's welfare plan.

The Mulhollands argue that the benefits were paid by IBC, and not by the Fund, and as such, they are not reimbursable. The Mulhollands also argue that IBC's administrative costs are also not reimbursable. The Fund contends that the benefits were paid by the Fund, and IBC simply acted as an administrator and provided stop-loss insurance. Because the Mulhollands' benefits were paid by the Fund, and stop-loss insurance does not convert the Fund into an insurer, the Fund argues that they are able to seek reimbursement.

In Bill Gray Enterprises, Inc. Employee Health and Welfare Plan v. Gourley, 248 F.3d 206 (3d Cir. 2001), our Court of Appeals explained the relationship between a self-funded employee benefit plan, its administrator, and the purpose and effect of stop-loss insurance. In Bill Gray, a self-funded employee benefit plan sought reimbursement of benefits it paid to its participant. Id. at 209. Through a subrogation and reimbursement clause in the plan document, the plan retained rights of subrogation and reimbursement against all plan participants and third parties for medical benefits paid by the plan. Id. The plan also purchased stop-loss insurance from an insurance company to cover benefit payments exceeding $40,000.

Id. It also engaged an outside administrator to process its claims. Id. at 211. The plan participant argued that the plan was precluded from seeking reimbursement--pursuant to a state statute prohibiting such reimbursement--because it was not a self-funded plan, and thus not subject to ERISA but rather state law. Id.

The court held that a self-funded employee benefit plan does not become an insurer because it has purchased stop-loss insurance. Id. at 214. It explained that "[e]mployee benefit plans that purchase stop-loss insurance are not insuring plan participants, but insuring the plan itself in the event a catastrophic medical event requires the plan to pay out large sums to an individual participant." Id. The court admonished, however, that

> we recognize that a self-funded ERISA plan may purchase such a large amount of stop-loss insurance that it appears as if the plan is no longer operating as a self-funded employee benefit plan but rather effectively operating as an insurance company. In this instance the purchase of large amounts of stop-loss insurance may be evidence that the plan is attempting to retain the financial security provided by insurance coverage while at the same time reap the benefits of ERISA preemption, including the avoidance of state laws regulating reimbursement.

Id. The court held that because there was no evidence that the Bill Gray Plan purchased an excessive amount of stop-loss insurance, it did not reach the issue of whether the purchase of

large amounts of stop-loss insurance effectively makes a self-funded ERISA plan an insurance company for ERISA preemption purposes. Id.

Here, the Fund argues that the relationship between the Fund and IBC is the same as the plan's relationship with the claims processor and the insurance company in Bill Gray. The Fund contends that its purchase of stop-loss insurance does not convert it into an insurer. According to the Fund, it pays IBC a total cost of claims processed by IBC in a given month, plus retention, which is a monthly charge per participant paid to IBC for its services rendered, unless the total exceeds the stop-loss attachment.

The Mulhollands contest the Fund's position. They argue that the Fund has provided no evidence, other than its unsupported statements, that the benefits paid to the Mulhollands were paid out of the Fund. Additionally, the Mulhollands have provided correspondence from IBC's general counsel to the Mulhollands that states, "For your information, QCC [Insurance Company, IBC's wholly owned subsidiary] considers the Fund to be a fully insured plan--not a self-funded plan." (Pl.'s Summ. J. Mot. Ex. D.)

The Fund is correct that simply because it has stop-loss insurance it is not automatically considered to be an insurer, and the Mulhollands have not provided any evidence that the Fund

purchased an excessive amount of stop-loss insurance. Thus, the fact that the Fund had stop-loss insurance during the relevant time period does not mean it did not pay benefits to the Mulhollands, and it does not mean that it is subject to state law.

The Bill Gray case cannot, however, address the question whether the Fund actually paid the Mulhollands' benefits out of its own funds. To support its position, the Fund has supplied an affidavit of Regina C. Reardon, Esq., the Fund Administrator since September 17, 1997. (Def.'s Summ. J. Mot. Ex. 2.) Reardon states, "As a result of the February 19, 2001 accident, Plaintiffs incurred costs for medical treatment and prescription drugs which were paid as covered benefits by the Fund. The Fund paid medical and prescription benefits along with associated administrative costs in the amount of $27,736.52." (Id. ¶ 11.) The affidavit, however, does not attach any records evidencing that the payment for Mrs. Mulhollands' medical bills came out of the Fund.

To further support its position, the Fund has supplied several copies of "Explanation of Benefits" statements from IBC, and these documents state, "These health benefits are entirely funded by the employer. IBC provides administrative and claims payment services only." (Def.'s Summ. J. Mot. Ex. 6.) These documents, however, do not identify the member's name, the ID

number, claim number, provider number, or group number. There is nothing linking these documents to the Mulhollands, and there is nothing evidencing that these documents were even created for a participant in the employee benefits plan at issue here. The only identifier on these IBC documents is one explanation of benefits statement addressed to "Regina C. Reardon."[5]

The Fund also relies on a Subrogation Acknowledgment and Reimbursement Agreement signed by the Mulhollands. The Acknowledgment reads in relevant part:

> [A]s a condition precedent to the payment of benefits to the undersigned or his/her assignee or on his/her behalf by the Fund, the undersigned hereby acknowledges and agrees that the Fund shall have the right of subgrogation and/or reimbursement to the extent of such benefits hereafter or previously paid as a consequence of said injuries in the event of the undersigned's recovery against any party/parties either by way of or settlement, verdict or otherwise . . . the undersigned hereby agrees to make a refund to the Fund or reimburse the Fund the total amount paid by it in the event the undersigned's net recovery is equal to or greater than the total amount being paid to the undersigned or to his/her assignee or on his/her behalf, otherwise said refund and/or reimbursement shall be limited to the amount of undersigned's recovery.

(Def's Summ. J. Mot. Ex. 2.) This document, although possibly relevant to the issue of the Fund's ability to assert a lien, is not dispositive of the issue of whether the Fund actually paid the benefits to the Mulhollands. Indeed, the acknowledgment

[5]It is unclear on its face whether IBC sent Reardon that particular document in her capacity as Fund administrator, or whether this explanation of benefits statement is for a medical service Reardon herself obtained.

states that the Fund is only entitled to reimbursement for "the total amount paid by it." Finally, the Fund relies on the Services Agreement with IBC, but, as mentioned above, that agreement does not delineate whether it applies to medical treatment, prescription drugs, vision, etc., but rather the entire welfare plan.

Conversely, to support their position that the benefits paid to the Mulhollands were not paid out of the Fund, the Mulhollands rely on the fact that the Fund has not presented any evidence to demonstrate that the Fund paid their medical bills. The Mulhollands also rely on the statement from IBC's general counsel to the Mulhollands' attorney that "QCC [Insurance Company, IBC's wholly owned subsidiary] considers the Fund to be a fully insured plan--not a self-funded plan." (Pl.'s Summ. J. Mot. Ex. D.)

Additionally, the Mulhollands refer to the language in the SPD, which states that "the Fund provides health insurance benefits for hospitalization, doctor visits, and certain other medical care . . . for you and your eligible dependents through the Personal Choice Program . . . administered by QCC Ins. Co., a subsidiary of Independence Blue Cross." (Id. Ex. A, at 3, 17.) The SPD continues, "The Plan pays directly for, or self-insurers other benefits including dental, vision, prescription drugs, disability, mental health treatment, medical emergency, allergy, child care, physical fitness and education. . . . The Board has

contracted with outside providers to process the claims for certain of these benefits, including prescription drugs, mental health treatment, medical emergency, allergy, child care, and vision. . . ." (Id. at 4.) The Mulhollands interpret this language as evidence that the medical benefits are "insured" and the other listed benefits are self-insured.

In its Reply brief, the Fund provides additional evidence to support its position that it is an entirely self-funded plan. It supplies a second affidavit of Regina Reardon, which attaches bills from IBC to the Fund for May 2006, as well as checks paid by the Fund to IBC in May 2006. (Def.'s Reply Ex. 1.) Reardon explains that IBC charges the Fund for all of the charges IBC has incurred for health care services. (Id. ¶ 6.) The Fund is responsible for paying the total amount of claims, minus any savings, plus the fee IBC charges for its administrative services. (Id. ¶¶ 7-10.) Based on this, Reardon states that "the Fund pays medical claims, not only on behalf of Plaintiffs, but on behalf of all participants," with the only exception occurring "in those months in which the Fund's stop loss protection applies." (Id. ¶ 19.)

Cross-motions for summary judgment, like any summary judgment motion, may only be resolved if there is no genuine issue of material fact. See Iberia Foods Corp. v. Romeo Jr., 150 F.3d 298, 302 (3d Cir. 1998) (citation omitted). An issue is

"genuine" if it is supported by evidence such that a reasonable jury could return a verdict in the nonmoving party's favor. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). A fact is "material" if, under the governing substantive law, a dispute about the fact might affect the outcome of the suit. Id. In considering a motion for summary judgment, a district court may not make credibility determinations or engage in any weighing of the evidence; instead, the non-moving party's evidence "is to be believed and all justifiable inferences are to be drawn in his favor." Marino v. Industrial Crating Co., 358 F.3d 241, 247 (3d Cir. 2004)(quoting Anderson, 477 U.S. at 255).

Initially, the moving party has the burden of demonstrating the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). Once the moving party has met this burden, the nonmoving party must identify, by affidavits or otherwise, specific facts showing that there is a genuine issue for trial. Id. Thus, to withstand a properly supported motion for summary judgment, the nonmoving party must identify specific facts and affirmative evidence that contradict those offered by the moving party. Anderson, 477 U.S. at 256-57. A party opposing summary judgment must do more than just rest upon mere allegations, general denials, or vague statements. Saldana v. Kmart Corp., 260 F.3d 228, 232 (3d Cir. 2001).

The parties' cross-motions for summary judgment must be

considered separately. Addressing the Fund's motion first, prior to filing its reply brief, the Fund had failed to meet its burden. Its only evidence to support its position that the Mulholland medical bills were paid out of the Fund was (1) subject to credibility determination (Reardon's statement in her affidavit), (2) subject to challenge (anonymous explanation of benefits statements from IBC), and (3) not dispositive (the acknowledgment form signed by the Mulhollands, the Services Agreement with IBC). The Fund's reliance on this evidence and its unsupported statements also were insufficient to demonstrate the absence of a genuine issue of material fact as to who paid the Mulhollands' medical bills.

The Fund, however, has provided additional evidence in its reply brief.[6] It supplied an IBC bill and Fund payment check to IBC for May 2006. It also supplied a second affidavit of the plan administrator, who states again that the medical benefits for all plan participants, including the Mulhollands, are paid by the Fund, and not through an insurance policy provided by IBC. This evidence, although not as precise as statements from 2001

[6]The Court has discretion to decline to consider new facts or arguments raised in a reply. See Laborers' Int'l Union v. Foster Wheeler Corp., 26 F.3d 375, 398 (3d Cir. 1994). Because the facts and arguments raised in the Fund's reply are material to the resolution of this case, and because the Mulhollands will have a chance to respond to this new information, the Court will consider it.

that specifically show that the Fund paid a certain amount for Mrs. Mulholland's medical bills, demonstrates that the Fund does pay plan participants' health care benefits. What the evidence does not show, however, is whether the claims paid were for all benefits, including medical, or only for the "other benefits" as defined in the SPD.

The Fund argues that this distinction, which is argued by the Mulhollands, is illusory. The Fund argues that even though the SPD uses the term "health insurance benefits," the SPD makes it clear that it is the Fund that is providing those benefits. (Def.'s Reply at 7.) Additionally, the Fund states that "participants, who are not familiar with the ASA [agreement with IBC], it may appear as though IBC is providing their coverage. However, the reality is, that the Fund must reimburse IBC for the claims that it pays pursuant to the terms of the ASA." (Id.) The Fund further states that its relationship with IBC is exactly what the contract between them is titled--IBC simply provides administrative services, and not insurance for medical care, and that all the benefits it provides to its participants are paid by it, and not by IBC.

Determining whether this evidence is sufficient to meet the Fund's burden of proving that there is an absence of genuine fact as to whether the Fund paid for the Mulhollands' medical bills, necessarily implicates the determination of whether the

Mulhollands have identifed specific facts and affirmative evidence that contradict those offered by the Fund, which also serves to determine whether they have met their own burden for summary judgment.

Prior to the Fund submitting additional evidence in its reply, the strongest proof to support the Mulhollands' position was the fact that the Fund had not provided any specific evidence that the medical bills were paid out of the Fund. Indeed, a moving party can meet its burden of showing the absence of genuine fact by "'showing'--that is, pointing out to the district court--that there is an absence of evidence to support the nonmoving party's case." Celotex, 477 U.S. at 323. The supplemental affidavit of the plan administrator and the attached bills, however, weakens the Mulhollands' strongest argument. The Mulhollands also support their position with the SPD language, which they claim distinguishes between medical health benefits and self-insured prescription, vision, etc. benefits, as well as the representation from IBC that the employee benefits plan is not a self-funded plan.

At this point, however, neither party has sustained its burden of proof. Even though the Fund has submitted evidence that it pays IBC large amounts of money for its participants' claims, that evidence only relates to May 2006, and not to 2001 when Mrs. Mulholland was injured and received treatment.

Further, that evidence does not demonstrate why type of claims it pays. Even though the Fund takes issue with the Mulhollands' interpretation of the SPD, neither the Reardon affidavit nor the bills and checks assuage that misinterpretation. Moreover, the Fund does not address IBC's statement that the Fund is not self-insured, other than to deny it. This issue alone--that IBC, which purportedly acts only as an administrator and stop-loss provider for the Fund, categorizes that Fund as "insured"--raises an issue of material fact, and the Fund must do more to discredit that fact than to "strenuously object" to it. (See Def.'s Reply at 4.)

The Court recognizes that discovery has closed in this case, and because both parties have submitted motions for summary judgment, each side purportedly has presented its best case. The Court also recognizes that this case is amenable for summary resolution, and these outstanding issues may be readily determined if the parties had one more opportunity to address them. Consequently, the Court will deny without prejudice both parties' motions, and will direct each side to refile its motion addressing, and limiting it to, the precise issues identified above.

This holding, however, only applies to the medical bills incurred by Mrs. Mulholland. The Mulhollands concede that, based on the language in the SPD, the "Local 1776 Fund self-insures

prescription drug benefits." (Pl.'s Summ. J. Mot. at 11 n.3.) Even though the Fund has not submitted any proof with regard to whether it actually paid Mrs. Mulholland's prescription benefits out of the Fund, this concession, in combination with the plan language of the SPD, evidences an absence of material fact as to this issue. Consequently, it still must be determined whether the Fund has the right to be reimbursed for the benefits it paid.

2. Whether the Fund authorizes the right to subrogation

The Mulhollands argue that because the Trust Agreement requires that any payment out of the plan's funds be authorized by a unanimous vote of the Trustees, and because the Fund has not provided any evidence that the Trustees unanimously voted to allow the right of subrogation, then the Fund is not permitted to recover the benefits paid to the Mulhollands.

The Fund contends that the right of reimbursement is clearly delineated in the SPD, and the language of the SPD was unanimously approved by the Fund's Board of Trustees in accord with their powers and fiduciary obligations to the Fund.

The Mulhollands' narrow reading of the Trust Agreement does not comport with the fiduciary duties of the Trustees. Trustees are required by ERISA to discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries, for the exclusive purpose of providing benefits to

participants and their beneficiaries, and for defraying reasonable expenses of administering the plan. Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570 (1985) (citing 29 U.S.C. §§ 1104(a)(1)(A), 1103(c)(1)). The Trust Agreement explicitly incorporates these ERISA provisions. (Pl.'s Ex. A; Def.'s Ex. 2, Section 3.6.) Additionally, the Trust Agreement provides that the Trustees are empowered to "do all acts, whether or not expressly authorized herein, which the Trustees may deem necessary or proper for the protection of the property held hereunder." (Id. at Section 5.10(e).) Further, the Trustees "shall have full power to construe the provisions of this Agreement, the terms used herein, and the by-laws and regulations issued hereunder. Any such determination and any such construction adopted by the Trustees in good faith shall be binding upon all of the parties hereto and the beneficiaries hereof." (Id. at Section 5.18.)

The provision in the Trust Agreement cited by the Mulhollands is in the section titled "Use of Fund," which delineates the Trustees' authority to pay expenses, collect contributions, pay benefits according to the SPD, establish a reserve, and "by unanimous vote, provide for a plan of payment of authorized benefits out of the Trust Fund itself; provided, however, that such payments can be legally made and that same are

in full compliance with all statutory and legal requirements." (Id. at Section 5.2.) A plain reading of this provision does not support the Mulhollands' contention that the right to seek reimbursement must be evidenced by a specific vote. Rather, the provision simply provides that the implementation of any benefits plan that would use money from the Fund must be approved by unanimous vote, which makes sense considering the responsibilities of the Trustees, as required by ERISA and set forth in the Trust Agreement, to protect the Fund and its participants and beneficiaries. Because the Mulhollands were part of an existing plan which provided them benefits, it can be presumed that their benefits plan, as described in the SPD, had already been approved by a unanimous vote.

Additionally, a plain reading of this provision actually contradicts the Mulhollands' other argument that their benefits were not paid "out of the Trust Fund." By arguing that reimbursement of any payments made "out of the Trust Fund" must have been pre-approved, they are tacitly conceding that their benefits were paid by the Fund, rather than by a separate insurer. Otherwise, if their benefits had been paid by a separate insurer, there would be no need for a unanimous vote under their interpretation of Section 5.2(e).

The requirements of ERISA and the terms of the Trust Agreement mandate that the Trustees act in the best interest of

the Fund and its participants and beneficiaries, and the Trust Agreement gives the Trustees authority to do what is necessary and proper in order to fulfill their fiduciary duties. As discussed above, the SPD allows the Fund to be reimbursed for benefits it paid out of the Fund, which comports with the Trustees' fiduciary duties. Further, the Trustees have full power to interpret the terms of the benefits plan, and only a finding that they acted arbitrarily and capriciously would serve to disrupt their interpretation. See Abnathya v. Hoffman-LaRoche, Inc., 2 F.3d 40, 45 (3d Cir. 1993)(stating that when an ERISA plan affords the administrator discretionary authority, a district court's grant of summary judgment is made under an arbitrary and capricious standard, and under this standard of review, an administrator's decision must be affirmed unless it was "without reason, unsupported by substantial evidence or erroneous as a matter of law"). Because the Mulhollands have not provided any evidence that the Trustees's interpretation of the Trust Agreement and SPD was made in bad faith, the Fund's right to seek reimbursement of self-insured benefits stands.

The right of the Fund to seek reimbursement for the benefits it paid is also supported by the acknowledgment signed by the Mulhollands. The Mulhollands argue that the waiver is unenforceable because there is no proof that they "knew of their legal rights to oppose Defendant's unjustified subrogation claim

or that they deliberately intended to relinquish said rights." (Pl.'s Reply at 6.) Even though the general principle of waiver "involves the intentional relinquishment of a known right, and thus it must be shown that the party charged with the waiver knew of his or her legal rights and deliberately intended to relinquish them," Shebar v. Sanyo Business Systems Corp., 544 A.2d 377, 384 (N.J. 1988) (citation omitted), here, the Fund's right of subrogation is independent of whether the Mulhollands signed an acknowledgment of that right. The acknowledgment, however, serves to evidence that the Mulhollands were informed of that right.

Thus, the Fund is entitled to summary judgment on its claim for reimbursement of the amount it paid in prescription benefits for Mrs. Mulholland.

3. Whether either party is entitled to attorneys fees and costs

Both parties argue that they are entitled to attorneys' fees and costs pursuant to ERISA section 502(g), which provides,

> (1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. § 1132(g).

The Court will reserve decision on this issue and will

address it in consideration of the parties' renewed summary judgment motions.

III. CONCLUSION

For the reasons expressed above, the parties' cross-motions for summary judgment as to whether the Fund is entitled to be reimbursed for medical benefits Mrs. Mulholland received are denied without prejudice. The parties are directed, as detailed in the accompanying Order, to renew their motions on this precise issue. Because the parties did not specifically address the Fund's right to recover its administrative costs, the parties are directed to address this issue in their renewed motions as well. Additionally, the parties may also revisit their request for attorneys fees and costs in response to this supplemental briefing. The Fund's motion for summary judgment is granted as to its right to be reimbursed for the prescription benefits paid to Mrs. Mulholland.

Dated: September 25, 2007 s/ Noel L. Hillman

At Camden, New Jersey NOEL L. HILLMAN, U.S.D.J.